

Authorization to Exchange Health Care Information

Client Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

I authorize Kelley Nay, MS / Life Matters Counseling
to disclose to _____ and/or from _____ (client must initial box/es if checked)

Name and Organization: _____

Address (street, city, state, zip code): _____

Telephone number: _____

the following health care information:

_____ Health care information relating to the following treatment or condition:

_____ Health care information for the date(s) below:

_____ All health care information:

This authorization ends: _____ in 90 days; or _____ when the following occurs (but not longer than 90 days):

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1. Sign and date a revocation form. This form is available from Kelley Nay, Life Matters Counseling.
2. Write, sign and date a letter to the Kelley Nay, Life Matters Counseling to cancel the authorization; or
3. Sign, date and write "CANCEL" on the original form.

Once Kelley Nay, Life Matters Counseling gives out the information, Kelley Nay, Life Matters Counseling has no control over it. The recipient might re-disclose it. Privacy laws no longer protect it.

Patient or legally authorized individual signature Date Time

Witness/Therapist Date Time

Please Note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.